No. 84-1437

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

PETER V. ALEXANDER,
Petitioner,

v.

UNITED STATES OF AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

REPLY BRIEF FOR PETITIONER

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REPLY BRIEF FOR PETITIONER

I. The Indictment Failed to Provide Notice and Failed to Limit the Petit Jury to Facts Considered by the Grand Jury.

Notice of the specific charges of fraud returned by a grand jury—"which of course are among the important concerns underlying the requirement that criminal charges be set out in an indictment"—was not given in this case. *United States* v. *Miller*, 105 S.Ct. 1811, 1814 (1985), relying on *Russell* v. *United States*, 369 U.S. 749, 763-64 (1962). Nor did the grand jury find fraudulent, or even consider, the specific claims on which the petitioner was convicted. The government does not contend otherwise.

Despite these fundamental errors, the government nevertheless urges that certiorari should be denied—by ignoring the holding in *Russell*; by stating that the court of appeals did not address this issue, when it did; and by misconstruing this Court's recent opinion in *Miller*.

First, and contrary to the government's representation (Opp. 4), the court of appeals expressly addressed the indictment's sufficiency on the merits, but mistakenly concluded that any deficiencies in notice could be cured by a bill of particulars.[1] The issue of indictment sufficiency was thus ruled upon by the court of appeals, and is properly before this Court.

Second, the government does not challenge petitioner's contention that the indictment in fact fails to give adequate—or indeed any—notice of the specific claims alleged to be fraudulent. It does not contest that, under the terms of the indictment, the government was left free to choose from among any of six hundred forty-one patient claims and over three thousand patient services covered by the checks identified in the mail fraud counts in presenting its case on the respective counts at trial. *See* Petition for Certiorari 13-14. Instead, the government follows the court of appeals' analysis that the indictment's lack of specificity could have been ameliorated by a request for a bill of particulars. That was, however, precisely the argument made, and rejected, in *Russell* v. *United States*:[2]

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[1] The court of appeals stated that "we reject the contention that the indictment as a whole did not give adequate notice of the charges against Alexander; any need for further detail could have been applied by a timely-requested bill of particulars." Pet. App. 9a. The court of appeals also rejected the specific point that Count 1 failed to charge a critical element of the crime. Pet. App. 9a.

[2] The government also characterizes the failure to seek particulars as a matter of trial counsel tactics. *Russell*, however, also makes clear that a failure to seek particulars has no weight in evaluating whether the indictment itself is invalid. 369 U.S. at 769, n.16.

> It is argued that any deficiency in these cases could have been cured by bills of particulars. But it is a settled rule that a bill of particulars cannot save an invalid indictment . . . To allow the prosecutor, or the court, to make a subsequent guess as to what was in the minds of the grand jury at the time they returned the indictment would deprive the defendant of a basic protection which the guaranty of the intervention of a grand jury was designed to secure.

369 U.S. at 770.

From the grand jury transcript recently produced to the petitioner by government counsel, and attached to this reply as Appendix I,[3] it is apparent that a bill of particulars could have provided *no* information as to what was in the minds of the grand jury, since *no* specifics were ever identified to the grand jury. The precise evils identified in *Russell*—allowing the prosecutor to "guess" what was in the minds of the grand jury and to fail to present any specific evidence to the grand jurors at all—are thus cogently illustrated in this case.

The transcript of the sole witness to testify before the grand jury reveals that the government presented no evidence even of a mailing with respect to Count One.[4]

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[3] The government has represented to petitioner, and to the trial court, that this transcript (comprising hearsay testimony by Agent Powell) contains the only evidence that was presented to the grand jury. The government has also represented that no exhibits were presented to the grand jury; nor did any other witness appear. As far as we are aware, this is the first grand jury case brought to this Court where the complete grand jury testimony has been filed in the district court, and is consequently available to this Court.

[4] The government has suggested that petitioner is no longer pressing the special deficiencies of Count One before this Court. In fact, the petition specifically notes that Count One lacked the essential elements of a mail fraud offense, because not even a check is identified as being at issue. Pet. 9-10. The transcript of Mr. Powell's grand jury testimony now has revealed that a check (to support a mailing on that Count) was never identified to the grand jury. App. I 12a.

The witness, Agent Powell, instead started his description of the specific counts with Count 2. App. I 12a. With respect to all of the mail fraud counts, the grand jury heard no evidence identifying any particular claim or claims for services as false or fraudulent. The grand jury had no opportunity to reach its own conclusions on these issues, because no documents or exhibits were displayed to them. And the "testimony" of the summary witness was confined to "reciting" from the draft indictment that the prosecution asked the grand jury to return immediately after the recital was completed.[5]

In short, the grand jury transcript graphically demonstrates that the petitioner was convicted on the basis of "facts not found by" and "not even presented to" the grand jury which indicted him. *Russell* v. *United States*, 369 U.S. at 770. Under *Russell*, this failure even to present the underlying facts to the grand jury for its consideration "deprived[d] the defendant of a basic protection which the guaranty of the intervention of a grand jury was designed to secure." *Id.*

The government implicitly contends that this clear violation of *Russell* makes no difference, because this Court's recent opinion in *United States* v. *Miller* permits the narrowing of charges contained in an indictment. The critical point in *Miller*, however, was that the scheme on which defendant was convicted was "fully included within" the indictment. The defendant was fully and specifically apprised of the two charges against him; he was fully prepared to meet both; and there was no question that the facts underlying both charges had been presented to the grand jury.

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[5] *See* App. I 2a, 12a (Assistant U.S. Attorney asks the witness to "recite" preliminary factual matters, and for Counts 2-31, to "recite the date and amount of check."). The indictment was returned and filed on the same date as the grand jury testimony, May 9, 1983.

Here, by contrast, *none* of the allegedly fraudulent claims for services was actually identified in the indictment or to the grand jury, and the government was left free, according to "each passing vicissitude of the trial", to pick among hundreds of possible offenses to present to the petit jury. *Russell* v. *United States*, 369 U.S. at 768. In *Miller*, the government clearly alleged in the indictment a specific two-part scheme, and then only sought to prove one part at trial. The converse is true here: the government did not allege any specific fraudulent claims in the indictment or until trial. This is not then, a case where the fraud was narrowed, but rather a case where the specific fraudulent claims were not identified in the indictment at all.

It is no answer to say, as the government does in a strawman argument here, that the indictment *could* have alleged that all of the patient claims covered by the checks identified in the mail fraud counts were fraudulent, and that picking out certain claims is therefore an acceptable narrowing of the charges. The fact is that the government never alleged—in the indictment, before the grand jury, or at trial—that all the claims covered by the checks were fraudulent. To the contrary, they conceded that petitioner did perform some tests; did bill properly on some claims; did not improperly perform pregnancy tests with respect to some patients; etc. To prepare a defense it was therefore essential to know what specific tests that petitioner had billed for, or other fraudulent acts, the government and the grand jury alleged had or had not occurred. That information was never presented to the grand jury—and was presented to the defendant only at trial.

There can be no question that the indictment in this case did not convey notice of the specific charges of fraud that the petitioner had to meet at trial. It is equally clear that the grand jury in fact never heard or saw any evidence permitting it to conclude that specific patient

claim forms were or were not fraudulent. Under *Russell* and *Miller*, these are fundamental errors that undermine the integrity of the grand jury's scrutiny of charges prior to indictment, and make it impossible for the defense to prepare its case. In short, they violate the grand jury guarantees of the Fifth and Sixth Amendments.[6] These flaws could not be remedied by a bill of particulars, as the government now claims, because no evidence identifying the allegedly fraudulent claims had even been presented to the grand jury.

This Court should grant certiorari to correct the government's fundamental departures from the requirements of *Russell* and *Miller*. Alternatively, and in view of the Court's recent decision in *United States* v. *Miller*, we ask that this Court grant certiorari and remand to the court of appeals for reconsideration in light of that case.

II. The Issues Presented for Review Are Not "Fact Bound".

A. Peer Group Studies.

Although not qualified as expert witnesses, and unable to explain the results and assumptions underlying the "peer group" studies conducted by others, two government auditors were permitted to testify about evaluations of how the petitioner's practice compared to his "peer group." None of the documentation or computer studies from which these conclusions were drawn was produced prior to or at trial.

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[6] Ever since *Ex parte Bain*, 121 U.S. 1 (1887), which granted habeas corpus for lack of jurisdiction, and which was recently reaffirmed in pertinent part in *Miller*, it has been recognized that a trial court is without jurisdiction to convict of a felony offense not charged by the grand jury's indictment. Thus the government's contention that petitioner's trial counsel "waived" the defect by failing to raise it is without merit. Nor could federal criminal jurisdiction be conferred by consent, even if trial counsel for some inexplicable reason had wished to do so.

The government does not seriously contest that this testimony was hearsay, or that its admission violated the Confrontation Clause (which "protect[s] similar values"),[7] but instead urges that admission of the results was not plain error and that the issue is "fact-bound." Again, the court of appeals, recognizing that an objection was made to this testimony at trial, did not apply the "plain error" standard but instead resolved it on the merits. Pet. App. 5a n.6.[8] And while any hearsay-Confrontation Clause case is in some sense "fact-bound," the legal issue created by the erroneous admission of this testimony has significance well beyond the contours of this case.

The government contends that the hearsay nature of the "peer group" evidence had only one effect—to prevent petitioner's trial counsel from questioning the accuracy of the statistics themselves. Opp. 9. This effect alone was important. It appears (from underlying documents recently produced in discovery procedings relating to the pending § 2255 Motion) that the accuracy of the statistics, and the use made of those statistics could have been undermined by vigorous cross examination.

For example, with respect to the Blue Cross "peer group" study, auditor Crumpler would have had to concede that the ratio she used to identify the petitioner Dr. Alexander as number one or two in his peer group, was not the ratio recommended by the computer program designers to evaluate potential abuse. In fact, in the two categories identified by the programmers as significant,

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[7] *See California* v. *Green*, 399 U.S. 149, 155 (1976).

[8] The court of appeals recognized that the issue was "the inability of the witnesses offering [the studies] to answer pertinent questions on cross-examination." The court of appeals, however, proceeded on the erroneous assumption, inconsistent with the record, that these "studies" were admitted into evidence (and thus in some sense available for review at trial) when in fact they were not. Pet. App. 5a n.6.

the petitioner's billings were quite similar to other "peers", and did not even make the "top 25" with respect to several of the tests in question. This point would have directly contradicted the government's assertion at the beginning of its closing argument that petitioner was "the heaviest biller in this area of Blue Cross/Blue Shield for those type tests. That should get your suspicions aroused." C.A. App. 977-78.

Auditor Crumpler would also have had to concede that the "peer group" itself was incomplete (and any implied judgment of comparability weakened) because the computer studies evaluated only the use of tests identical to the ones used by petitioner—and did not take into account similar tests that other practitioners used interchangeably with the ones used by petitioner. Similarly, auditor Halloran departed from the computer program results, by finding evidence of "abuse" where the printout itself identified no such evidence.

Without the underlying documentation on which these auditors relied, a cross-examiner could find weaknesses only by listening to the auditors' incomplete descriptions of results on direct examination. With the documents in hand, glaring errors contained in the auditors' appraisal (but not revealed by their conclusory description of results) could have been attacked from a position of strength. Such an attack was crucial in this case, where much of the evidence was circumstantial, and where absent an effective cross-examination on these studies, the government could and did open its closing and rebuttal arguments by relying on these studies as "indicia of fraud." C.A. App. 977-78, 1026.

Computer results are only as strong as the assumptions and numbers on which they rest. Here the "results" derived from the computer printouts relied on by the auditors were demonstrably misleading, and selectively presented. Only if defense counsel had access to the underlying printouts and programs, however, could that be

demonstrated. It seems an elementary point that such underlying documents must be produced before "expert" testimony as to results is permitted. *See* Fed. R. Evid. 703-05, and Petition at 19. That point was, however, missed below. This Court should provide guidance to remedy the hearsay and Confrontation Clause problems that are inevitable when computer studies undergird opinion testimony, by granting certiorari on the second question presented.

B. Discovery.

The government represents to this Court—as it did below—that "open-file discovery" was permitted prior to trial. The court of appeals' refusal to remand for further investigation of other discovery issues, and the government's argument to this Court that remand is unnecessary, both rest expressly on that representation. *See* Pet. App. 11a, Opp. 10. As has frequently occurred in this case, the government has shifted its position yet again. The Assistant United States Attorney involved in litigating this case at trial has now stated to the trial court that "open-file discovery" was not permitted, and that instead "Rule 16 discovery" occurred. Testimony of AUSA Miller before district court, May 24, 1985. Of course, that characterization is not accurate, either, since auditors' workpapers, peer group studies and other analyses were not produced, pursuant to "Rule 16 discovery", even though they were material to the defense, and should have been produced under Rule 16, and under *Brady* v. *Maryland*, 373 U.S. 83 (1963). When a court is confronted with multiple and inconsistent shifts in the government's factual representations regarding discovery, the proper remedy is to order a remand to the trial court to resolve these issues, as contended under question 3 of the Petition for Certiorari.

CONCLUSION

For the foregoing reasons, together with those set forth in the Petition, a writ of certiorari should issue to review the judgment and opinion of the Fourth Circuit.

Respectfully submitted,

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June, 1985

APPENDIX

APPENDIX I

[1] IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
NORFOLK DIVISION

THE UNITED STATES OF AMERICA,
Plaintiff

v.

JOHN DOE,
Defendant.

TESTIMONY OF ORNRAN MICHAEL POWELL

Norfolk, Virginia

May 9, 1983

Before the United States Grand Jury

Appearances:

By: TOMMY E. MILLER, ESQUIRE
Assistant United States Attorney
Counsel for the Plaintiff

[2] ORNRAN MICHAEL POWELL, being first duly sworn testified before the United States Grand Jury as follows:

EXAMINATION

BY MR. MILLER:

Q. State your full name and occupation, please?
A. Name is Ornran Michael Powell. I am a special agent with the Department of Defense.

Q. Okay. Have you had occasion to review the proposed indictment charging United States of America v. Peter V. Alexander?

A. Yes, I have.

Q. And do you find it to be in conformity with the results of your investigation?

A. Yes, I do.

Q. What other agency outfitted are you investigating?

A. In the Virginia Health Department we assisted, Medicaid assisted me. CHAMPUS did and also Blue Cross and Blue Shield of Virginia audited some of the records in the case.

Q. Okay. Count one has a series of preliminary statements involving factual matters, could you recite?

A. Yes.

Q. Who is Peter V. Alexander?

A. He is a medical doctor and obstetrician/gynecologist who has a private practice in Virginia Beach, [3] Virginia, has had since the mid 70's.

Q. Where did they maintain the office from May 15th, 1978 or on or about March, 1979?

A. At 533 Newtown Road, Virginia Beach and then after that until the present really he has his office on Bayside Medical at 816 Independence Boulevard, Virginia Beach.

Q. Preliminary statement ends with December 7, 1982; is that correct?

A. That is.

Q. What happened on that date?

A. On that date, I and two other investigators carried out a search warrant at his office to seize various medical records.

Q. And those records have been used in the audit and examination of Dr. Alexander's claims against Blue Cross and Blue Shield?

A. Yes, sir.

Q. Paragraph four defines Medicaid, I believe?

A. Yes.

Q. What is that?

A. That is a program, majority of which is funded by the federal government and partially funded by the state of Virginia which provides medical assistance for families with dependents and also the aged, blind and disabled individuals who don't have enough money to pay for their medical services.

[4] Q. As provided for by Title 19 of the Social Security Act of 1965; is that correct?

A. Right. Federal law and the Department of Health and Human Services, which used to be called Health, Education, and Welfare, set up regulations and the Virginia Department of Health administers it and at all times throughout this period covered by this indictment the U.S. Government paid at least 50 percent of the cost of Medicaid.

The actual payment of bills is handled by the computer company in Richmond, Virginia which receives the claim forms from the doctors, processes them and sends the payment checks out to the doctors through the U.S. mail.

Q. Where is that computer company located?

A. 1905 Westmoreland Street, Richmond, Virginia.

Q. How does a doctor submit a claim?

A. He sends a standard form to the computer company. The number of the form is MAP-12. On this form he lists what medical services he claims to have provided to the patient, and then the computer company pays him based on that claim form and based on whatever standards they go by as to the maximum allowences.

Q. And how are the claims paid?

A. They send a check through the U.S. mails to the provider, to the doctor or hospital.

Q. That is the routine method of payment; is that [5] correct?

A. Yes.

Q. And at all times material to this indictment, was Peter V. Alexander submitting claims to Medicaid?

A. Yes, he did.

Q. Did he have a number?

A. Yes. He had a provider number 62-4945-1.

Q. Okay. And I believe he signed a physician participation agreement?

A. Right, under this agreement he agreed to accept the payment for Medicaid as a full payment for the services rendered, not to bill the patient for anything additional.

Q. All right. In addition to Medicaid, was there another program involved in this case?

A. Yes. There was the Department of Defense Program called CHAMPUS that stands for Civilian Health and Medical Program of the Uniformed Services. This is a program funded 100 percent by the federal government which pays medical benefits to dependents. In other words, spouses and children of people in the military.

In other words, people who are in the military or their wives or children are entitled to treatment care at military hospitals, but there are occasions when they have—they go to a civilian doctor when there not able to handle them at the doctor's office and CHAMPUS paid their bill in the [6] case and also billing for retired military people and their dependents. This was established according to federal law Title 10, US Code, Chapter 55 A and D, Department of Defense. Also set forth in the Naval officer's regulation 6010.8-R, which regulates how CHAMPUS charges and handled and paid.

Q. In addition to persons who you have mentioned, does it not also pay for expense to spouse and children of deceased, active duty and also for personnel for the spouses and children of deceased retired uniform forces personnel?

A. Yes.

Q. Okay.

A. And CHAMPUS as Medicaid pays its claims through what are called fiscal intermediaries. In other words, CHAMPUS enters into contracts with various insurance companies and the company—to handle their bill paying for them in regard to Virginia.

The fiscal intermediary between August 1, 1977 and September 30, 1981 was Blue Cross and Blue Shield of southwest Roanoke, located in Roanoke, Virginia, and from October 1st, '81 through the present the fiscal intermediary of Blue Cross of Blue Shield of South Carolina is located in Columbia, each of these agencies in return received claim forms from Dr. Alexander as well as other health care providers and then made payments to Dr. Alexander sending checks out to him through the U.S. mails to his office in [7] Virginia Beach.

The claimant makes his claim on a form 500 and a claim from 500 which he sends on to the fiscal intermediary and under CHAMPUS regulations when he signs that form, he is certifying that the medical care on that claim has really been provided to the patient whose name is listed on the form.

In other words all he is doing is certifying that he is telling the truth and he really claims to do this thing he put on the claim form, and, also, there are occasions when the CHAMPUS beneficiary—

For example suppose—if a military man retires and he has Blue Cross, he is eligible for insurance coverage at once and when that occurs, CHAMPUS regulations require the doctor to submit the claim form, indicate this other coverage so that we don't have two companies paying for the same procedure.

In other words, to avoid overpayment by the government and a third health care plan—in the indictment it is Blue Cross/Blue Shield of Virginia located in Richmond, Virginia, and there is an insurance claim to pay hospital, medical and surgical services established, under the authority of the code of Virginia 38.1-810.811 and here again, Dr. Alexander submitted claim to the Blue Cross and Blue Shield, in the provider number 01602 and he submitted health insurance claim form 95, that is what he used to indicate the name of [8] the patient, the patient's Blue Cross number and also what claim for medical services he claimed to have performed for the

patient, and as with the other two health care plans, Blue Cross/Blue Sheild of Virginia, he was on the claim forms to determine what the claim would be and have it mailed direct to him in the United States mail to his office in Virginia Beach, and that outlines the preliminaries in this indictment.

Q. Now, after seizing the records from Dr. Alexander's office and after auditing it and auditing the records.—

A. Yes, sir.

Q. And even prior to seizing the records, did you talk with various ex-employees of Dr. Alexander and ex-patients of Dr. Alexander?

A. Yes. I talked to people in both categories. He has had a number of the patients and over the years he has had a high number of employees. So there were a number of people who were exposed to the way he ran his office.

I also talked to a number of ex-patients of his who had seen him from time to time.

Q. What did you determine about his methods of doing business in relation to these three insurance providers?

A. Well, we determined as indicated in the indictment that he submitted on a routine basis claims to these three insurance providers for various medical tests and [9] procedures that he had in fact not really performed. He claimed on virtually every single claim to have performed a number of tests including a pregnancy test, a urinalysis and two different microscopic examinations of specimens taken from his female patients.

The purposes of the test, I should say, is to determine if there were various types of infections present, and on virtually all of the claims that he submitted to these three, Medicaid and CHAMPUS and Blue Cross of Virginia, he claimed to have performed all of these, but in fact from talking to his ex-employees and his patients, we determined that in most cases he had not done so.

In fact, in many cases he simply took the urine specimens and poured them down the toilet or down the sink without doing any test and he didn't run the pregnancy test at all. For the various microscopic tests, we found that in regard to the pregnancy test a number of women upon who he had performed various sterilizations and so he knew that they were sterilized. He made a claim and he claimed to have performed pregnancy tests on them.

Q. And these sterilization techniques, did they range from complete hysterectomy, tuliligation and removal of fallopian tubes and ovaries?

A. Yes, sir. All the patients that he performed of sterilizations we found instances in each case where he went [10] back and did pregnancy tests on them later.

Q. And was there a note in the records as to when he performed his pregnancy test? Did he routinely know that the patient thought they might be pregnant? Is that why he filed for the pregnancy?

A. Usually there was just a brief handwritten note, not even that. A brief note.

Q. He claimed to have done it?

A. He claimed, right.

Q. Did you make an examination of his purchase of pregnancy test for the records seized?

A. Yes. We looked at the purchase records over the years and found who he had done business with and we determined from about 1977 through the present, he purchased about 225 pregnancy test kits to perform 225 pregnancy tests.

Q. And just in the Medicaid area, how many pregnancy tests did he bill the government for on sterilized women?

A. 166 over the last five years.

Q. And you could only use one of these test kits for a pregnancy test?

A. Right, and along the same thinking, the urinalysis is the type of test he claimed to have performed by using the one urinalysis dip stick to dip into one specimen.

So in other words, one stick per specimen and from what I [11] believe it was from 77 to the present, he purchased approximately 200 urine dip sticks, but for these whom—these he made a claim to Blue Cross, he claimed to perform thousands of test per year.

Q. In fact, out of the purchase of the 200 dip sticks did he not send 100 of them back there for refunds and then he purchased 100 and sent them, then he purchased another 200 and then he sent them back for refunds and likewise for the various microscopic examination?

A. I feel that he did purchase this various dyes that he would need to take the specimens so that they could be examined promptly and they might be examined and the type he has was a small low powered type of microscope that would not have enough microscopic equipment to detect—to require him to see bacteria and might show what he was looking for in these various test.

Q. In fact, physicians who regularly conduct this type of microscopic examination would testify that the microscope Dr. Alexander had was totally inadequate for effectively performing these microscopic examinations; is that correct?

A. That is correct, yes, and also both CHAMPUS and Medicaid have a—required that they pay only for patient's who actually have some illness or injury.

In other words, they don't pay for routine [12] health care, for a woman's pap test and routine examination every six months or year. They don't pay for this, but what I fond on Dr. Alexander's claim forms was thereafter for every person with a common diagnosis of sickness, but we found—in talking with employees, we found that a good portion of his patients did come in simply for routine care which isn't covered by CHAMPUS and Medicaid leading to the inference that he put this diagnosis of illness on the claim form so that they would be covered by CHAMPUS and Medicaid.

Q. In addition, did the auditors find chargable a lot of blood pressure records?

A. Yes, sir. And for all the patients over six the blood pressure for the same person prevailed through a couple of years of visits and the same pressure would be listed on the charts of various patients and there are at least 400 patient's whose records were audited and in fact, some former employees have told us that you normally do not take a patient's blood pressure.

Q. Did you find the blood pressure equipment at the office when you did execute the search warrants?

A. There was not one in plain view. In other words, it didn't appear to be in plain view, but on the examination table, one of the investigators did find one. It didn't appear to be in use, though.

Also, there is the question of double billing to [13] CHAMPUS and Blue Cross and a number of—a number of them did have—eligible under both plans and we found though that when Dr. Alexander would submit to CHAMPUS he would fail to indicate on the form that the patient also had Blue Cross coverage. Also, the claim on the CHAMPUS form specifically says, "Does the patient have other coverage, yes or no," and in many places, we found that he would check the no block for—the information was checked. He had in a number of cases therefore paying duplicate for tests and operations that had already been paid by Blue Cross and CHAMPUS should have been paid only by Blue Cross since they are what this all—the first responsibility is to pay Medicaid and after that CHAMPUS comes in and pays the difference.

Q. There is something called the procedures code that are used in these billing procedures?

A. Yes. The doctor indicates what procedures are performed by a five-diget procedure code, and the procedure code is set forth in a booklet called the Physicians' Current Procedural Terminology. It is a thick volume that lists all the procedure codes for the various operations and office visits and tests that doctors will routinely perform and this is something that is standard use

throughout the medical profession and Dr. Alexander stated what procedures had been performed by these five-diget numbers and in some cases we found that Dr. Alexander would indicate on these claim forms.

[14] Q. The procedure he was billing for whether or not he had done it?

A. Right, he was claiming for work performed. We found that in some cases that the procedure he was claiming to have performed for—were more extensive than the procedure in fact performed. Take for example the code for office visits. The most extensive for an office visit is 90080 and also the code that would appear most frequently on these claim forms indicating that he performed a comprehensive service for his patient.

In other words, a physical examination and complete history and detailed counseltation, but from talking to the patients and to the former employees, we found that in most of the visits he did with these patient's were very much routine and customary.

In other words, the patient would come in and have a pelvic examination and she would have a preconference with Dr. Alexander, that would be it.

The auditors also examined his records and the methods and then CHAMPUS determined that most of the office visits could not be justified as maximum comprehensive and they moved him down a couple notches to file a brief and intermediary of care.

So in other words, he was overbilling the government for these various procedures—these various [15] office visits. He was billing for more extensive examination then he had really performed.

Q. And that reduction by the auditors was based on their review of Dr. Alexander's own files?

A. Right. They found the entries in his files did support an extensive and comprehensive—their only belief was to find that the patient was normal at that time, there were no problems or at the most one or two line handwritten entry was for preconference office visit

would—could expect considerable writing by the doctor as to patient's diagnosis and the patient's past history and problems, if any, and also general practice in the medical profession that when a patient has an operation that the follow-up visit to the doctor afterwards is included in the surgery fee.

In other words, the doctor does not charge extra for the visit after the operation. We found though that Dr. Alexander's patients, the first visit to him after the operation usually within a week or two afterwards, were billed separately to CHAMPUS and Medicaid.

In other words, he didn't include it in his standard surgical fees as the standard in the medical profession and as is required by CHAMPUS and Medicaid regulations.

And getting to the dollar amount now, the CHAMPUS auditors looked at Dr. Alexander's records of patients [16] who had CHAMPUS eligibility and compared what he claimed at that time were made and determine that at least $47,927.47 represented overpayment of either test not performed or improper double billings. The Blue Cross/Blue Shield of Virginia auditor for Blue Cross and Blue Shield found that they had overpaid him by at least $21,538.02 for various false claims submitted to them over the years and the investigators found that Dr. Alexander had overbilled them by least $20,874.25 and these claims were routinely sent to the—these three carriers and they in turn processed the claims, wrote the check to Dr. Alexander and sent them back to him by the U.S. mails.

Q. All right. Specifically, in the Count 1, I believe it is in paragraph five—six, Count 1—

A. Yes.

Q. Count 1 deals with one of these mailings, that is January 9, '81, the Defendant, Peter V. Alexander, received one of these checks by mail. The date is based on the date of the check, and there would be only at the most probably two or three days between the time the

check was directed to the health insurance plan and by the time it was received by Dr. Alexander.

I understand the payments came from Richmond, Roanoke or the farthest Columbia, South Carolina and Count 2 contains the same—essentially the same allegation that he [17] received a check from CHAMPUS in the case and he gives the check number and the check amount and the application is that is he received the check by mail as part of the scheme to defraud CHAMPUS.

In other words, he made these various false claims against CHAMPUS and that is the reason for the—he received the check back from CHAMPUS by the mail and Count 3 through, I believe, Count 12 all cover checks received from CHAMPUS and then starting with Count 13, we get into claims.

On all those, could you just recite the date and amount of check?

A. Count 2, the date is January 30th, 1981 and the Defendant received check number 9134473 from Blue Cross of southwest Virginia, Roanoke, Virginia in the amount of $1,451.46, which has been sent to him by the U.S. Postal Service.

Count 3, the date is February 24th, 1981 and he received a check number 9140754 from Blue Cross Blue Shield of southwest Virginia in the amount of $818.15.

Count 4, the date is June 2nd, 1981, check number 9162983 the amount is $1,255.55 from Blue Cross Blue Shield, southwest Virginia.

Count 5, dated January 7th, 1982. The check number is 00101877. The amount of the check is $2,816.65. The check was from Blue Cross/Blue Shield, South Carolina in [18] listing as the billing as intermediary CHAMPUS.

Count 6, the date is May 28, 1982. The check amount is $521.17. The check number is 00294858 from Blue Cross Blue Shield of South Carolina.

Count 7, the date is June 12th, 1982. The check number is 00306215. Check amount is $116.65 from Blue Cross/Blue Shield of Columbia, South Carolina.

Count 8 is dated August 13, 1982. Check number 00378075. The amount is $100.66 from Blue Cross Blue Shield of South Carolina.

Count 9 is dated September 6th, 1982 and the check number is 00415030 from Blue Cross/Blue Shield of South Carolina and the amount is $466.36.

Count 10 is dated September 30, 1982. The amount of the check is $1,161.49 and the check number is 00448239 from Blue Cross/Blue Shield of South Carolina.

Count 11. The date is November 9, 1982, check number is 00005707. The amount is $1,047.72 from Blue Cross/Blue Shield of South Carolina.

With Count 12 we begin the mail fraud counts involving Medicaid and beginning with Count 12 it alleges that on September 29, 1978, the defendant removed from a depository from mail box or in other words a mail box an envelope containing check number 0572239 from the computer company acting as an intermediary for Virginia Medicaid, the amount of [19] the check being $1,040.00.

Q. The previous checks that you discussed were addressed to 816 Independence Boulevard, Virginia Beach, Virginia; is that correct?

A. Right.

Q. And this check is at 533 Newtown Road, Virginia Beach, Virginia?

A. Right. That is back when he had the office on Newtown Road back in '78 and '79.

Q. Continue with Count 13.

A. Count 13 is dated October 27, 1978, a check to the Newtown Road address, check number 0593939 from the computer company and the amount is 1,345.50.

Count 14 is dated January 12th, 1979. The check was mailed to the address on Newtown Road. Check 0661370

from the computer company in the amount of $3,082 and no cents.

Count 14, date is February 23rd, 1979, addressed to Newtown Road and number 0695534 from the computer company in the amount of $1,428.

Count 15, date is February 23rd, 1979, addressed to Newton Road and number 0695534 from the computer company in the amount of $1,428.

Counts 16, date is April 13th, 1979 and this subsequent check is for Medicaid addressed to the Bayside address, 816 Independence Boulevard, Virginia Beach. The check number is 0734869 from the computer company in the amount of $1,983 and no cents.

Count 17, the date is July 20th, '79, for the [20] Independence boulevard address, check number 0113359 in the amount of $1,097.

Count 18, the date is September 28th, 1979, and the check number is 0169970, the amount of $697.

Count 19, the date is January 19, 1980. The check number is 0263572 the amount is $2,158.

Count 20, the date is February 22nd, 1980. The check number is 0293785, the amount of $2,037.

Count 21 has a date of May 16th, 1980, check number 0378374 in the amount of $872.

Count 22 is August 22nd, 1980, check number 0141100 in the amount of $1,185.

Count 23, the date is January 16, 1981, the check number is 0287140. The amount is $3,050.

Count 24 is March 27, 1981, check number 0360082 in the amount of $1,234.

Count 25, the date is July 3rd, 1981, check number 0507247 in the amount of $804.

Count 26, January 26, 1982 check number 0729379 in the amount of $699.30.

Beginning with Count 27, we start with the mail fraud counts against Blue Cross/Blue Shield of Virginia, Richmond, Virginia.

In Count 27 it charges that on June 10th, 1980, Dr. Alexander received at Bayside Medical Plaza, 816 [21]

Independence Boulevard check number 070330 from Blue Cross/Blue Shield of Virginia in the amount of $1,756.65, this check being sent by the U.S. Postal Service.

Count 28 charges that on July 7, 1981, he received another check from Blue Cross, check number 531088 valued at $469.

Count 29, the date is July 15th, 1980. The check number is 105770 in the amount of $896.35.

Count 30, the date is January 13, 1982, check number —I'm missing page 34 in my copy.

Count 31, the date is May 26, 1981. Check number 482667 in the amount of $958.65.

Count 32. Beginning with count 32, we're getting into very specific false claims involving CHAMPUS.

Count 32 charges that on or about August 22, 1980 Peter Alexander presented to CHAMPUS a claim for medical services allegedly given to Josephine Cortese, a patient of his and in this false claim, he claimed that Josephine Cortese did not have any other active insurance.

In other words, on this CHAMPUS form, he is required to disclose that the patient had other insurance, if a patient did. She did have in fact a policy under Blue Cross/Blue Shield of Virginia, but on this claim form, he checked the box that indicated no, she did not have other insurance.

[22] He was aware that she had other insurance because he himself had billed Blue Cross of Virginia for the same procedure for which he was billing CHAMPUS.

Count 33, the date is August 26, 1980. At this time, Dr. Alexander billed for services performed for another patient, a Miss Margret Adamson in claim the CHAMPUS, did you have any other insurance stating the—he signed the form indicating no, she had no other insurance when in fact she had a policy under Blue Cross and Blue Shield of Virginia, thus billing for the operation he already billed Blue Cross and then he billed CHAMPUS.

As the result of this claim, CHAMPUS paid him $600, whereas if he had truthfuly disclosed the existance of her

form, they would have paid $400 and checking into contracts the payment had-already been paid by Blue Cross.

Count 34 charges that on or about January 16, 1981, he billed CHAMPUS for procedures performed on Louise Ison I-s-o-n and here again, he indicated falsely on his claim form that Louise did not have any other insurance coverage when in fact she has a Blue Cross/Blue Shield of Virginia policy which had already made payment for a number of laboratory test which they shoud have paid but which CHAMPUS was not obligated to play because of his falsification of the claim form caused CHAMPUS to pay these test.

Count 35 charges that on or about April 14th, [23] 1981, Dr. Alexander billed CHAMPUS for medical services allegedly supplied to Frances Cox, a patient of his when he knew that that claim he submitted to CHAMPUS was false because he claimed—in his claim, he alleged that he had performed a pregnancy test on March 16, 1981, but he also was aware that he had done sterilization on her on January, 10, 1981 by removal of her fallopian tubes, or bilateral salpingectomy.

So in other words, he performed a sterilization in January 16, '81, but on March 16, '81, he claimed to perform a pregnancy test on her and was paid by CHAMPUS for doing so.

Count 36 charges that on or about June 2nd, 1981, he billed CHAMPUS for procedures allegedly performed for Lois Donaldson and this claim was false in two different ways.

Number one, the patient has surgery performed for her on March 1st, 1981 which involved a dilation of uterus and a D & C and a perminent sterilization by tubiligation. This operation taking place on November—excuse me, May 1st, 1981.

He then submitted CHAMPUS claim form for a subsequent post operative visit which was fraudulent in two cases.

Number one, his payment for this post operative visit has been taken care of for the May 1st operation, but he billed CHAMPUS for a separate visit.

[24] Number two he claimed that this May 1981 visit he performed the regular—a test on the Lois Donaldson only a week after the sterilization was performed on her and here again, CHAMPUS still paid on this claim relying on the assertions made on this claim form.

Count 37 charges that on or about June 30th, 1981, he submitted a claim for services performed on Patricia Repko, R-e-p-k-o, a patient of his and on this claim form to CHAMPUS he falsely stated that she did not have any other active insurance when in fact she did have a Blue Cross/Blue Shield policy of Virginia which had made payment to him.

So in other words his submission of falsified claims caused CHAMPUS to pay for claims which should and were paid by Blue Cross of Virginia.

Count 38. January 7, 1982, he presented a claim to CHAMPUS for medical services supplied to Evangeline Berka, B-e-r-k-a, and this claim is fraudulent in that he claimed to perform several tests including a urinalysis pregnancy test and two different smears which he had in fact had not performed and we know that he did not perform them because we talked to this patient Mrs. Berka and she told us he did not do that.

Q. She would have recalled whether he had given a uninalysis?

A. She said he did not take a urine specimen at all [25] and she said she didn't receive a pregnancy test. She has had no examination from him, period.

Count 39 also involves Mrs. Berka. Dr. Alexander submitted another claim, the claim visit on May 14, 1982 and this claim was fraudulent in two different ways.

Number one, first of all, Mrs. Berka had had an operation on December 18, 1981 and the visit was a follow-up to that operation and so the payment for the follow-up visit was covered in the surgical fee, but he billed

CHAMPUS for a separate visit, separate office visit which he should have not done.

Also, here again, the patient told us that she had not given a urine specimen. She has not had a pregnancy test. She had not had any of the procedures that Dr. Alexander billed or said he performed.

So this claim is fraudulent in two ways.

Number one he billed for office visits which had already been paid in his surgical fee and number two he billed or various tests that in fact had not been performed.

Count 40 is a falsified claim submitted to Medicaid. This involves a lady by the name of Patricia J-e-f-f-c-o-a-t who was working under cover for Virginia Medicaid at the time. She got a Medicaid card and went in posing as a Medicaid patient and received an office visit in which Dr. Alexander examined her. She did not give any urine [26] specimen. She did not have any smears taken from her or microscopic examinations and she did not have a pregnancy test and she was aware that she had not received this. However, Dr. Alexander turned around and used the Medicaid card presented to him and billed Medicaid for procedures which she knew that he had not performed.

Q. That offense occurred on August 17, 1981?

A. Yes. He submitted the claim on January 4, 1982.

Q. And all of this occurred in Virginia Beach, Virginia within the Eastern District of Virginia; is that correct?

A. Yes, sir.

Q. Grand jury have any questions of Agent Powell?

A JUROR: I was sort of interested in who initiated this investigation.

THE WITNESS: It began by a complaint from one of his former employees. She contacted a physician in the local area who referred her either to Blue Cross of Virginia or to Virginia Medicaid and the Department of Defense joined in the case later when it became clear that he also submitted a number of claims to CHAMPUS.

A JUROR: Did he have a lot of lab work done on these people or no lab work?

THE WITNESS: Virtually none. He did—some employees have told us he did the urinalysis on a few patients. [27] He would dip the dip stick in the specimen —he simply did not have the supplies or equipment to do the microscopic examination and he only had about 235 test pregnancy kits to perform the test.

A JUROR: Did he use the lab outside or—sometimes they use the lab at the hospital to do work for them. He did not use nothing like that?

THE WITNESS: No, for his past. Now, he has those sent thought the—performed the test that he billed for that he did not do, he did not have sent to an outside lab either.

A JUROR: Do you have any credentials where he graduated and where—

THE WITNESS: Well, it's a really complicated story. He was born in Romania.

He came to the United States and received his training and residence in Berlin, then graduated and went to Pittsburg, then moved from there and set up practice in North Carolina and moved to Virginia in the mid 70's, and he is a duly licensed physician in the Virginia Department of Medecine.

A JUROR: Did he have nurse or anything in his office?

THE WITNESS: Not a trained registered nurse, no, sir.

A JUROR: A woman or somebody in the office that [28] takes this mail in and the doctor does not actually get the mail. The nurse takes it in?

THE WITNESS: He had a lady working for him. One lady is combination secretary and receptionist. She handles the mail. They take administrative—they send it up, take the mail in and send it to us, then they take the check, they gave the check directly over to Dr. Alexander.

In other words, they just sort of received it and handed

it over to him. She was aware of everything that was going on in his office.

MR. MILLER: If I might call your attention to the language of the indictment in the mail fraud count, it says Peter V. Alexander removed and caused to be removed from an authorized depository of the mail, and it also sites 18 USC, Section 2, in each mail fraud count which is the—which we have gone over a number of times in the past which is the aiding and abetting, if you cause someone to do something in furtherance of a crime.

A JUROR: I know you're concerned with the indictments and the mail fraud issue, but is there any relationship or any involvement of the AMA that you would—I'm talking about his medical practice. Is there any relationship between you and some board that maybe interested in whether he is practicing medicine?

THE WITNESS: Well, his peers do considerable [29] damage to the reputation. In fact, he has been denied staff privileges at all but two hospitals in the Tidewater area. So his peers apparently have reservations about his capability and they are the major medical authorities in the world of medicine. In Richmond, there are a number of large concerns about his practice.

A JUROR: I was just trying to see if a new patient was maybe going there, maybe he is not giving them what would be considered adequate treatment. Maybe you have some viewpoint about his books for the next few months and so forth?

THE WITNESS: He has cut it down to virtually nothing. Starting in about February of this year, he did so, he cut his schedule down to virtually nothing.

A JUROR: He does not have any appointments scheduled until October?

THE WITNESS: That is correct.

A JUROR: And that was believed to be as a result of the execution of the search warrant at his office; is that correct?

THE WITNESS: Yes, his practice diminished considerably after that.

A JUROR: There are no malpractice suits running concurrent with this investigation?

THE WITNESS: Well, not as a direct—not tied [30] directly with the investigation. He has had malpractice suit in the the past, not getting into those extensively.

MR. MILLER: There being no further questions, Agent Powell may step down.

(Whereupon the witness was excused.)

[31] CERTIFICATE OF COURT REPORTER

I, Katherine A. Pennello. Shorthand Reporter, certify that I recorded verbatim by Stenotype the proceedings in captioned cause before the United States Grand Jury, Norfolk, Virginia, on May 9, 1983.

I further certify that to the best of my knowledge and belief the foregoing transcript constitutes a full, accurate and complete transcript of said proceedings.

Given under my hand this 16th day of June 1983, at Norfolk, Virginia.

/s/ Katherine A. Pennello
KATHERINE A. PENNELLO